Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041010	A. BUILDING: _____ B. WING _____	08/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIEDMONT CHRISTIAN HOME	1510 DEEP RIVER ROAD HIGH POINT, NC 27265

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D 000	Initial Comments The Adult Care Licensure Section and the Guilford County Department of Social Services conducted an Annual survey on 08/02/17 to 08/03/17.	D 000		
D 299	10A NCAC 13F .0904(d)(3)(A) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (A) Homogenized whole milk, low fat milk, skim milk or buttermilk: One cup (8 ounces) of pasteurized milk at least twice a day. Reconstituted dry milk or diluted evaporated milk may be used in cooking only and not for drinking purposes due to risk of bacterial contamination during mixing and the lower nutritional value of the product if too much water is used. This Rule is not met as evidenced by: Based on observations, and interviews the facility failed to serve eight ounces of pasteurized milk at least twice a day to residents in the Special Care Unit (SCU). The findings are: Review of the menu spreadsheet revealed: -Milk (8 ounces) was to be served at breakfast, lunch and dinner for all diets on 08/02/17 and 08/03/17. -A snack menu was not listed, so it could not be determined if milk should be served with any snack service. Observation on 08/02/17 at 10:15 am revealed snacks of peanut butter crackers and cranberry	D 299	—— All SCU residents are offered 8 ounces of pasteurized milk at least twice a day. An individual glass is placed for each resident. Milk is stocked and available always for those residents that request it at anytime. A plan has been →	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mary P. Morgan | TITLE: Administrator | (X6) DATE: 9/01/2017

Reviewed and excepted on 09/12/17.
Diana Spalding RN, BSN

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D 299	Continued From page 1 juice or water were offered and served by the Personal Care Aides (PCA). Observation on 08/02/17 from 12:03 pm to 1:00 pm of the lunch meal served revealed: -There were 19 residents were served in the SCU dining room. -Beverages were prepared, poured, and served by the PCAs. -Beverages served included water, tea and juice. -Milk was not offered or served in the dining room. -There was no milk in the mini-fridge in the SCU. Observation on 08/02/17 at 2:40 pm of the milk on hand in the kitchen revealed: -A total of 144 8oz containers of whole milk in the refrigerator. -One gallon of 2% milk located in the refrigerator. Observation on 08/02/17 from 5:30 pm to 6:30 pm of the dinner meal served revealed: -There were 19 residents were served in the SCU dining room. -Beverages were prepared, poured, and served by the Personal Care Aides (PCAs). -Beverages served included water, cranberry juice, and tea. -Milk was not offered or served in the dining room. -There was no milk in the mini-fridge in the SCU. -There were 2 residents requesting milk but told, by the Activities Director there were told there was "no milk over here" and given water instead. Observation on 08/03/17 at 8:30 am of the milk on hand in the kitchen revealed: -A total of 128- 8oz containers of whole milk in the refrigerator. -One gallon of 2% milk located in the refrigerator.	D 299	established and implemented to stock and rotate to meet residents' requirements.	8/4/17

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D 299	Continued From page 2 Interview on 08/02/17 at 12:30 am with the Dietary Manager (DM) revealed: -"The residents don't like milk". -The residents in the SCU could ask for milk if they wanted it. Interview on 08/02/17 at 5:20 pm with a resident in the SCU revealed she liked milk but only gets it with her cereal. Interview on 08/02/17 at 5:20 pm with a second resident in the SCU revealed she liked milk and wanted milk but only gets it with her cereal. Interview on 08/03/17 at 10:13 am with two residents in the SCU revealed: -If they were served milk they would drink it. -They both wanted milk with the cookies that were served for a snack. -They would like to have milk with other meals but did not get it. Interview on 08/03/17 at 12:10 pm with the Activities Director revealed: -There was no milk stored in the SCU. -If any resident asked for milk she would get it from the kitchen. -Milk was served with cereal in the morning. -The resident must ask for the milk. -She was not aware she must serve milk to the residents at least twice a day in the SCU. Interview on 08/03/17 at 1212 pm with a Personal Care Aide (PCA) revealed: -There was no milk stored in the SCU. -If any resident asked for milk she would get it from the kitchen. -Milk was served with cereal in the morning. -The resident must ask for the milk.	D 299		

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D 299	Continued From page 3 -She was not aware she must serve milk to the residents at least twice a day in the SCU. Interview on 08/03/17 at 2:02 pm with the DM revealed: -There was no milk stored in the SCU. -If any resident asked for milk she would get it from the kitchen. -Milk was served with cereal in the morning. -The resident must ask for the milk otherwise they have no way of knowing the residents want milk. -Only healthy shakes were stored in the SCU mini-fridge. -He was not aware he must serve milk to the residents at least twice a day in the SCU. Interview on 08/03/17 at 2:17 pm with the Administrator revealed: -She was not aware milk was not served in the SCU 2 times a day. -The DM was responsible for ordering the milk. -The dietary staff was responsible for delivering the food and drinks to the SCU according to the menu.	D 299		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.	D 358		

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D 358	Continued From page 4 This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner for 1 of 5 sampled residents (Resident #1) with a physician's order for methotrexate 2.5 mg. The findings are: Review of Resident #1's current FL2 dated 07/03/17 revealed: -Diagnoses included hypertension and rheumatoid arthritis. -A physician's order for methotrexate 2.5 mg, five tablets weekly. (Methotrexate is used to treat certain cancers and to treat rheumatoid arthritis when other treatments have been unsuccessful. Methotrexate helps to reduce further joint damage related to arthritis and preserves joint function (Web MD). -A physician's order for hydrocodone/acetaminophen 5/325 mg (a narcotic pain reliever) 3 times a day as needed for pain. Review of Resident #1's record revealed: -Signed physician's encounter sheet dated 07/19/17 continuing methotrexate 2.5 mg, five tablets weekly, and hydrocodone/acetaminophen 5/325 mg (a narcotic pain reliever) 3 times a day as needed for pain. -A order dated 07/20/17 prescribing hydrocodone/acetaminophen 5/325 mg one tablet at bedtime, and one tablet 3 times a day as needed for pain. Review of Resident #1's Resident Register	D 358	— The facility will assure that medications are administered as ordered. The following measures have been put in place: a. Review all medications per admission and compare to the MARS for accuracy. b. Follow-up review in one week on administration of medications. c. Pull MARS to review on random basis to ensure for accuracy. d. Inservice conducted with staff (Med Techs) on Medication Administration and on policy and procedures to report concerns. (See Attachments) 8/18/17 e. Resident Care Director will monitor for compliance. ongoing	

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D 358	Continued From page 5 revealed the resident was admitted to the facility on 07/18/17. Interview on 08/02/17 at 10:00 am, during the initial tour, with Resident #1 revealed: -She had been at the facility for 2 to 3 weeks. -She came from her home to live at the facility. -She was receiving her medications that she had at home except for one of her arthritis medications. -She was experiencing worsening pain from her arthritis. Review of Resident #1's July 2017 and August 2017 electronic Medication Administration Record (eMAR) revealed: -Methotrexate 2.5 mg, five tablets weekly was not transcribed on the eMAR for July 2017 or August 2017 -Methotrexate 2.5 mg, five tablets weekly was not documented as administered for 07/18/17 through 07/31/17. -Methotrexate 2.5 mg, five tablets weekly was not documented as administered for 08/01/17 through 08/02/17. -Resident #1 had not received methotrexate 2.5 mg, five tablets weekly for the 2 weeks since she was admitted to the facility. Continued review of Resident #1's July 2017 and August 2017 electronic Medication Administration Record (eMAR) revealed: -Hydrocodone/acetaminophen 5/325 mg one tablet at bedtime was listed on the eMAR for July 2017 and August 2017 and documented as administered at 7:00 pm each night from 07/20/17 to 08/01/17. -Hydrocodone/acetaminophen 5/325 mg one tablet one tablet 3 times a day as needed for pain was listed on the eMAR for July 2017 and August	D 358		

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D 358	Continued From page 6 2017 and documented as administered for 2 doses (08/01/17 at 11:04 am and 08/02/17 at 7:48 am). Observation on 08/03/17 at 2:08 pm of Resident #1's medications on hand for administration revealed 13 tablets remaining of 15 methotrexate 2.5 mg tablets dispensed on 07/02/17 from a local pharmacy. Telephone interview on 08/02/17 at 4:55 pm with a representative for the contracted pharmacy provider revealed: -The pharmacy was responsible for entering orders for medications and treatments on the eMAR. -The pharmacy had received Resident #1's FL2 dated 07/03/17 and physician order for methotrexate 2.5 mg, five tablets weekly on 07/19/17. -Resident #1's medication orders were entered onto the eMAR on 07/19/17 except for methotrexate 2.5 mg, five tablets weekly because the order did not specify the day of the week to administer methotrexate. -The pharmacy was waiting for information from the facility regarding the day of the week to schedule the methotrexate 2.5 mg, five tablets weekly and was the reason methotrexate was not on the eMAR. -The pharmacy had no documentation for the facility staff member that the pharmacy spoke with or to whom the pharmacy faxed the request regarding the need for the facility to provide a day of the week for administration of methotrexate 2.5 mg, five tablets weekly for Resident #1. Interview on 08/02/17 at 5:30 pm with Resident #1 revealed: -She had been taking methotrexate for her	D 358		

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D 358	Continued From page 7	D 358		

arthritis "for years".
-She had not been administered methotrexate since she came to the facility (on 7/18/17).
-She asked the medication aides about her methotrexate, but they did not know why she had not received the medication.
-She needed methotrexate because "it was the important one [medication] for her arthritis".
-She had received an order for a scheduled narcotic pain medication, but she did not like to take it.
-She felt the arthritis and the pain had gotten worse since she had not been receiving methotrexate.

Telephone interview on 08/03/17 at 9:00 am with the facility's contracted Nurse Practitioner (NP) revealed:
-She had seen Resident #1 the day after she was admitted on 07/19/17 for a new resident examination.
-Resident #1 was supposed to continue methotrexate 2.5 mg, 5 tablets once weekly as ordered.
-The NP had not discontinued methotrexate 2.5 mg, five tablets weekly for Resident #1.
-She had not received notification that Resident #1's order for methotrexate 2.5 mg, five tablets weekly needed to have a day of the week specified by either the facility or the contracted pharmacy.
-The NP did not have a preference for a day of the week; any day would be fine, just use the same day each week.
-She would expect Resident #1 to be administered methotrexate 2.5 mg, five tablets weekly as ordered on the FL2 dated 07/03/17 and physician's orders dated 07/19/17.
-She ordered Resident #1's narcotic pain medication on 07/20/17 for a scheduled dose at

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D 358	Continued From page 8 bedtime and as needed during the day due to the resident's complaint about increased pain from arthritis. -Receiving the methotrexate would help to decreased pain and discomfort for patients with rheumatoid arthritis severe enough to require methotrexate. -She was not aware Resident #1 was not receiving methotrexate 2.5 mg, five tablets weekly for controlling her rheumatoid arthritis. Interviews on 08/03/17 at 11:20 am and 2:40 pm with the Resident Care Director (RCD) revealed: -The contracted pharmacy entered the resident's medication orders onto the eMARs and placed the orders in a pending file on the computer for the facility's approval in order for the medications to start appearing on the eMAR for the medication aides (MA) to administer. -She had not been contacted by a representative from the contracted pharmacy for Resident #1's methotrexate 2.5 mg, five tablets weekly regarding the need for an administration day of the week specified before it could be added to the resident's eMAR. -The physician had signed physician's orders for medications using the pharmacy generated list of medications on 07/19/17 and methotrexate was not included on the list of medications. -She was responsible to review residents' medications in the pharmacy pending file and release the orders when verified. -She was responsible to review the physician's encounter sheets and verifying any continued or added medications. -She was not aware methotrexate 2.5 mg five tablets once weekly was not on the eMAR and had been overlooked in her review. -She was not aware Resident #1 was not receiving methotrexate 2.5 mg as ordered.	D 358		

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D 358	Continued From page 9 -No MA had informed her Resident #1 was asking about her methotrexate for her to investigate why it was not being administered. -Resident #1 had brought a supply of most of her medications when she came to the facility 07/18/17. -Methotrexate 2.5 mg was in the supply of medications she brought from home. -The pharmacist manager of the contracted pharmacy had explained today (08/03/17) Resident #1's methotrexate 2.5 mg order, five tablets weekly was held at the pharmacy for a specific day of the week to administer the medication. -She would choose today (Thursday, 08/03/17) as the day of the week and make sure methotrexate 2.5 mg order, five tablets weekly was added to Resident #1's eMAR. Telephone interview on 08/03/17 at 2:40 pm with the pharmacy manager from the contracted pharmacy revealed: -The pharmacy entered all the orders from the FL2, office visits, faxes or physician telephone orders onto the eMAR. -The facility released the orders when reviewed for accuracy, then the orders appeared on the residents' eMARs for administration by the MAs. -Resident #1's methotrexate 2.5 mg, five tablets weekly was placed in a stack at the pharmacy for contacting the facility for additional information (day of administration). -The pharmacy documentation was incomplete as to when the pharmacy contacted the facility and who was contacted. -He would make sure Resident #1's methotrexate was added to the eMAR today (08/03/17). Interview on 08/03/17 at 3:00 pm with a first shift MA revealed:	D 358		

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D 358	Continued From page 10 -She did not routinely review residents' medications compared to the physicians' orders. -She thought the pharmacy entered the orders and the RCD was responsible for reviewing the orders and approving the orders so the orders would appear on the eMAR for the MAs to administer. -Resident #1 had not asked her about her methotrexate for arthritis. -Resident #1 had a pain reliever (narcotic) that she could request as needed. -She was not aware Resident #1 was ordered the methotrexate 2.5 mg, five tablets once weekly. Interview on 08/03/17 at 3:15 pm with a second shift MA revealed: -She was not aware of the scheduled morning medications for Resident #1. -Resident #1 did not have methotrexate 2.5 mg, five tablets weekly listed on eMAR for the evening medications to be administered.	D 358		
D 466	10A NCAC 13F .1308(b) Special Care Unit Staffing 10A NCAC 13F .1308 Special Care Unit Staffing (b) There shall be a care coordinator on duty in the unit at least eight hours a day, five days a week. The care coordinator may be counted in the staffing required in Paragraph (a) of this Rule for units of 15 or fewer residents. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure a care coordinator was on duty in the Special Care Unit (SCU) at least eight hours a day, five days a week.	D 466	The office for the Care Coordinator is being established in the Special Care Unit in Room 213. This office will be completed by September 30th, 2017. The care coordinator →	9/30/17

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D 466	Continued From page 11 The findings are: Observations on 08/02/17 at various times in the SCU revealed: -The current census in the SCU was 19 with a licensed capacity of 24. -There was one medication aide (MA), two personal care aides (PCAs) and a activities director on duty in the unit. -There was no care coordinator on duty in the unit. Interviews on 08/02/17 at 9:00 am with a MA revealed: -There was a Resident Care Director (RCD) for the SCU and her office was located on the Assisted Living (AL) side. -She stated the RCD usually walked through the unit to check on the unit regarding any changes with the residents, and was usually there long enough to walk through. -She stated the RCD walked through every day to check on things and would help out if needed but does not have an office in the SCU. Interview on 08/02/17 at 10:00 am with a PCA revealed: -She stated the RCD walked through the SCU to check on things with the MA. -The RCD would help with staffing or care of the residents if needed. -The RCD's office was located in the front of the building on the Assisted Living (AL) side. Interviews on 08/03/17 at 12:12 pm with a second PCA revealed: -There was a Resident Care Director (RCD) for the SCU and her office was located on the Assisted Living (AL) side.	D 466	will be on duty in the unit eight hours a day, five days a week per regulation.	9/30/17

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D 466	Continued From page 12 -The RCD usually walked through the unit to check on the unit check on things and would help out if needed but does not have an office in the SCU. Interview on 08/03/17 at 2:26 pm with the RCD revealed: -She was the RCD for the SCU for many years. -She is also the RCD for the AL side. -Her office is located at the front of the building on the AL side. -She does not have an office on the SCU. -She walked through the SCU every day and checkd with the MA about issues, staffing and will fill in if needed as PCA or MA. -The total hours spent in the SCU per day varied from a quick walk through to filling in as a PCA or a MA. Interview on 08/03/17 at 2:45 pm with the Administrator revealed: -There was a RCD for the SCU and the office for the RCD was located on the AL side up front with all of the other offices. -She did not realize a RCD needed to be on duty in the unit at least 8 hours a day, 5 days a week.	D 466		

Medication Administration

Collin Runyon, PharmD, BCGP
RxCare, Inc.
Program Code: MED808

Outline

- Proper storage of medications
- Instillation of ophthalmic products
- Instillation of otic products
- Suppository insertion
- Use of inhalers
- Subcutaneous injections

Proper Medication Storage

- Prescription and non-prescription medications must be store under locked security.
- Medications should be stored in clean, well-lighted, well-ventilated area.
- Medication storage areas should only me accessible to staff responsible for medication administration and administrator/person in charge.
- Store medications away from cleaning agents or hazardous chemicals.

Proper Medication Storage

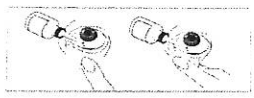
- Topical/external medications should be stored in a designated area separate from oral and injectable medications.
- Store refrigerated medications at 36-46 ° F.
- Do not store refrigerated medications in refrigerator containing non-medication related items.

Proper Medication Storage

- The only "stock" medication at the facility should be non-prescription medications or the following prescription medications:
  - Irrigation solution
  - Diagnostic agents
  - Vaccines
  - Water for injection and normal saline for injection

Ophthalmic Drops

- Wash hands thoroughly with antibacterial soap
- Shake eye drop container
- Tilt patient's head back and gently lower lid forward to create a pouch.
- Instill one drop in pocket



Dry Powder Inhalers

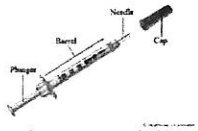
- Foradil
- Spiriva
- Advair Diskus
- Flovent Diskus
- Serevent Diskus
- Pulmicort Flexhaler
- Asmanex

Dry Powder Inhalers (DPIs)

- Keep DPIs dry
- Load just prior to use
- Hold DPI level either horizontally or vertically:
  - Horizontal loaders: Advair, Flovent, Serevent
  - Vertical loaders: Asmanex, Foradil, Pulmicort, Spiriva.
- Patient should exhale fully away from DPI and raise the device to their mouth.
- The patient should inhale quickly and deeply through the mouth.
- Remove the DPI from the patient's mouth and have them hold their breath for about 10 seconds.
- The patient should rinse their mouth if the DPI contains an inhaled steroid (Advair, Flovent, Asmanex, Pulmicort).

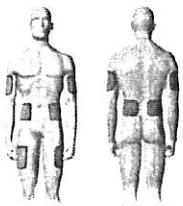
Subcutaneous Injection

- Subcutaneous injection – a shot of medication injected into the layer between the skin and the muscle.
- Parts of the syringe:
  - Needle
  - Barrel
  - Plunger
- Before injecting: verify patient's name and the name of the medication on the label matches the box/container to check the right patient has the right medication.



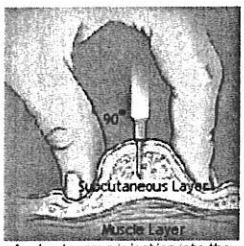
Subcutaneous Injection

- Make sure medication is not expired and there are no crystals or lumps in the vial.
- Sites for subcutaneous administration:
  - Upper Arm
  - Abdomen
  - Thigh
  - Lower Back



Sites on the Body Where a Subcutaneous Injection Can Be Given

Subcutaneous Injection



A subcutaneous injection into the fatty layer of tissue under the skin.

- Wipe area with an alcohol swab and let dry.
- Remove needle cover.
- Hold syringe in writing hand.
- Grasp skin with hand not holding syringe and use wrist to inject the needle. Once needle fully inside skin, push down plunger.
- Remove needle at same angle it was inserted.
- Gently wipe are with sterile gauze pad.

QUESTIONS??????

NC Division of Health Service Regulation ---Adult Care Licensure Section
Plan of Protection

To be completed by DHSR/DSS Staff

Facility Name: Piedmont Christian Home License #: AAL-041-080

Rule Violation Cited: 10A NCAC 13F .1004(a) Medication Administration

(Complete separate form for each Rule Violation) Type B

PLAN OF PROTECTION

(To be completed by facility staff. Attach additional pages if needed)

What immediate action will the facility take to abate the violations?

Review all medication Orders, Follow up review x1 week re Administration of Medication. Periodically pull MARS to review on Random bases to ensure accuracy. In service with staff (CMP's) re Medication Administration and the protocol to report any concerns. DCS will monitor for compliance. Compared to the MARS for accuracy.

Describe your plans to ensure residents are protected from further risk or additional harm?

For Unabated Violations (Type A1, Type A2 and Unabated Type B) only:

Please provide a date by which the facility will be in compliance with the rule area cited *(required)*. Date: _____

Facility staff completing this form:

[signature] LCD	8/3/17	[signature]	8-3-17
Name/Title	Date	DHSR/DSS staff	Date